PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG_		05/02	2/2012
	OVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
		is represent the findings of a Complaint Investigation					
F 170 SS=E	483.10(i)(1) RIGHT T SEND/RECEIVE UNG		F	170			
		right to privacy in written uding the right to send and that is unopened.					
	by: The facility census to facility provided mail of residents. Based on i	is not met as evidenced staled 35 residents. The delivery service to 22 of the interviews, the facility failed is received prompt mail at delivering mail on					
	Findings Included:						
	resident #8 reported t did not receive mail o	at 1:30 pm on 4-23-12, he residents in the facility n Saturdays. The resident son responsible for this task days.					
	service staff F revealer mail Monday through He/she reported he/sl responsible for obtain the residents. Staff F delivered mail to the control of the service of the servic	t 8:15 am on 4-24-12, social ed residents received the Friday but not on Saturdays. The was the individual ing and delivering mail to reported the post office community of Anthony on the facility mail into a					

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for pursing homes, the findings stated above are disclosable 90 days

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG _		05/0	2/2012
NAME OF PROVIDER OR SUPPL		NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
received Satur when he/she  During an interadministrative mail delivery she/she report on Saturdays placed Saturd locked box. It to the resident During an intericensed nurse facility policy service and done of the mail on Saturdays placed Saturd locked box. It to the resident facility policies and government of the mail on Saturdays service and done of the mail on Saturdays service and done of the facility may policies and provide sand provide saturdays and misapprovide samples of the facility of the samples of	taff F in rday mareturned a staff G service ed the in and contay's made/she is to the form of the try in a staff G service and contay's made E report procedured a staff G service with a service was a service with a service and in a service with a service of the	dicated the residents ail on the following Monday of to work.  It 12:30 pm on 4-25-12, confirmed the residents' is Monday through Friday. The residents did not receive mail on the facility post office aid staff delivered the mail following Monday.  It 3:00 pm on 4-26-12, forted he/she did not find the redure for resident mail fink the facility had one.  It ave a system in place that the resident mail following Monday.		226			

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F 226	implement the screen Findings included:  On 4-26-12, review housekeeping staff hi facility failed to conduct the conduct the conduct the new emodification of the conduct the conduct from the Kansas Board of Conduct the conduct the person housekeeping staff labackground check inform the lick conduct the conduct the incomplete and indicated the incomplete and indica	of the personnel record of red on 2-17-12, revealed the let a criminal background aployee.  If the personnel file for the 2-27-12 revealed the facility curse aide registry verification  If the personnel file for the on 2-13-12, revealed the licensure verification and of Nursing until 4-24-12.  It is a side of the licensed staff Enel record of the licensure verification and of nurse or the direct care staff, and lensure verification from the licensed nurse. It is a side of the licensed nurse. I	F	226			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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F 253 SS=E	backgrounds checks, follow their Personnel Manual on all applica. The abuse policy sec accusation is substanterminated and report licensing agencies and as warranted, within 2 The facility failed to dimmediately notify the including the state agabuse, neglect, and earlies and the facility failed to imprevention/prohibition not thoroughly performs creenings and failed informing staff the apple notified immediate or exploitation allegated 483.15(h)(2) HOUSE MAINTENANCE SERT The facility must proving maintenance services sanitary, orderly, and This REQUIREMENT by:  The facility census to residents resided on to observation, interview facility failed to provide necessary to maintain interior for 20 of 20 residents residents residents interior for 20 of 20 residents.	e facility would perform references, and would Policy and Procedure ints and current employees. Ition I. revealed, "if the tiated, the employee will be red to the appropriate state d other proper authorities, 24 hours of the decision". evelop a policy to e proper authorities, ency of all allegations of exploitation.  Inplement their of resident abuse policy by ming new employee to develop an abuse policy propriate authorities would ly during an abuse, neglect, ion.  KEEPING & EVICES  ide housekeeping and a necessary to maintain a		253		

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F 253	odors that permeated Findings included: On 4/19/12 at 8:30 a. observation revealed odor on the North hall carts and trash parket. The linen and trash carts presented with a and the lids failed to for offensive urine odor p. North hallway.  On 4/23/12 at 7:15 a. wicker linen and trash. Hallway with a strong Observation on 4/23/resident #3 sat in his/urine odor permeated On 4/23/12 at 3:30 p. urine odor was less n linen and trash carts of trash.  Observation on 4/24/rurine odor was again linen carts that sat in a.m. and again at 12:revealed the laundry a baskets remained full A strong urine odor per the wicker baskets.	m. during initial tour, a strong offensive urine lway near the soiled linen d midway down the hall. arts contained bagged to the top of the carts. The a wicker weaved material it tightly. The strong permeated to the end of the m. observation revealed the a carts sat in the North urine odor present.  12 at 1:39 p.m. revealed the recliner chair. A strong the room. m. observation revealed the oticeable and the wicker contained no soiled linen or  12 at 7:30 a.m. revealed the strong near the trash and the North Hallway. At 11:00	F	2253			

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	ROVIDER OR SUPPLIER  COMMUNITY CARE O	ENTER		STREET ADDRESS, CITY, STATE, ZIP ( 212 N 5TH AVE ANTHONY, KS 67003	CODE		
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F 253	resident #3 ambulat independently as he A strong urine odor room. At 8:18 a.m. presented with a pill stains that covered surface. A strong upermeate the room, the door closed, the the hallway. At 11:5 the resident sat in hurine odor remained his/her bed remained observation reveale presented with 4 was the top shelf. The rounmade and a strongroom.	ed in his/her room  s/she dressed himself/herself. continued to permeate the the resident's unmade bed ow top mattress with brown about 2/3rds of the mattress rine odor continued to  After leaving the room with strong urine odor permeated 52 a.m. observation revealed is/her recliner and the strong I in the resident's room and d unmade. At 2:06 p.m. d the resident's closet ter resistant mattress pads on esident's bed remained g urine odor permeated the	F2	253			
	environmental tour in observations and in The north hallway of trash barrels with tigodor was less but st room. Maintenance about the odor probing the old one, cleaned maintenance building maintenance building urine odor for a whill he/she shampooed Observation in the rapproximately 9:15 leaned against box.	ontained new soiled linen and ahter lids. The stale urine ill lingered near resident #3's staff I reported he/she knew lem since January 2012. family brought in a new orings and he/she removed It it and stored it in the					

Facility ID: N039001S

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F 253	mattress and box spri #3. Both the box spri smelled of a stale urir once the smell was in was hard to get rid of mattress and box spri often he/she changed reported he/she had r mattress since Janua the resident a new pil I stated he/she was the change out the mattresknowledge housekee changed out the mattresknowledge housekee changed out the mattrest cleaned the pillow matter brought it for the resident and was to spray the and let the mattress adaily. Staff I reported right outside resident system would pick up other rooms on that he reported that resident urine odor because the leaked and urine got reported that he/she scarpet at least once a that all the rooms record a month. Staff I providincluded a list of resident numbers that staff har completed cleaning the reported he/she did not reported he/she did n	Staff I confirmed that the ngs belonged to resident ngs and the mattress are odor. Staff I reported that the inside of the mattress it without just buying a new ngs. When asked how out the mattress, staff I not changed out the ry when the family brought low type mattress set. Staff ne only person who would less and that to his/her oing and nursing had not tress as he/she had not tress set since the family lent. Staff I reported that do the resident's room daily mattress with a disinfectant ir dry in the resident's room that the return air duct was #3's room and that the air the odor and carry it to allway. At 9:30 a.m. staff I #13's room also had a ne resident's urostomy on the carpeted floor. Staff I shampooed the resident's week. He/she confirmed never a deep cleaning once ded a cleaning schedule that	F	253			

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F 253	During an interview of care staff A reported mattresses and that it every so often, steam outside. He/she also plastic covers to protegetting wet.  On 4/24/12 at 8:20 a. care staff O reported consisted of placing etop of the mattress, it more incontinent padand then additional in On 4/24/12 at 10:40 a housekeeping staff J the resident's rooms of he/she did not wash at the aides' responsibilificatility deep cleaned monthly. When aske resident #3's room stand his/her own bed aurine odor was becausincontinent. Staff J stale clean the resident's matter spray it with Lysol dis On 4/24/12 at 12:30 planting an interview, reoffensive urine odors he/she had suspected carts for a while now change and the desir atmosphere he/she duse. Staff G reported	n 4/23/12 at 4:38 p.m. direct resident #3 had two he facility changed them out a cleaned and aired them reported the resident had ect the mattresses from  m. during an interview direct the bedding for resident #3 extra incontinent pads on the nen a mattress cover, then s, then the bottom sheet, icontinent pads.  a.m. interview with revealed he/she cleaned all daily. Staff J reported beds and that was a part of ities. He/She reported the all the resident's rooms d about the urine odor in aff J reported the resident was tated that he/she did not nattress or bed except to infectant every day.  b.m. administrative staff G, egarding the strong on the North hallway, said d the wicker linen and trash but because of culture	F	253			

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F 253	he/she wanted to get clean because he/she material retained the no time table as to wh complete the floor str.  On 4/24/12 at 12:42 provided additional in shampooed and stea mattress weekly. At he/she was well awar on the North hallway, believed the odor was room.  On 4/24/12 at 1:00 p. direct care staff C rev #3's bed air out so the made it later in the data to buring an interview where we well and it later in the data to buring an interview where	n. Staff G also reported that the floors stripped and a thought the flooring urine odor. Staff G provided then the staff would start or apping and cleaning.  o.m. direct care staff A formation that the facility m cleaned resident #3's 12:45 p.m. staff A reported are of the strong urine odors. Staff A reported he/she is coming from resident #3's m. during an interview with realed he/she let resident at it was dry before he/she are it was dry before he/she are at it was dry before he/she are at it was dry before he/she are at it was his/her understanding was outside in the shed aff I switched out. Staff P or know how often witched the mattress out but at let him/her know.	F	253			

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F 253 F 279 SS=D	hallway.  483.20(d), 483.20(k)( COMPREHENSIVE COMPREHENSIV	that permeated the North  1) DEVELOP CARE PLANS  e results of the assessment d revise the resident's of care.  elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive  escribe the services that are an or maintain the resident's nysical, mental, and		253	DEPICIENCY)		
	by: The facility census to sample included 17 re observation, interview facility failed to developlan for 2 of 17 sample	taled 35 residents. The					

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F 279	- Review of resident orders dated 3/31/12 diagnoses: gout, con (Cardio Obstructive F (diabetes mellitus) wire complication, macula chronic pain, constipation chronic kidney disease allergic rhinitis and G reflux disease).  Review of the resider (minimum data set) wireference date) of 4/1 with a BIMS (brief into 00/15 (severe cognitive extensive assist of 2 transfers and dressing services.  The comprehensive of included a problem do following information: The resident was re-a 4/4/12 with suppleme During and since the experienced fluctuating consciousness and mexperienced disorgang psychomotor retardates summary included that larger room to accomwho stayed with the ridid so by their own chresident made decision his/her family and had	#1's signed physician's revealed the following gestive heart failure, COPD rulmonary Disease), DM thout mention of retina, ation, atrial fibrillation, see, sleep disturbance, ERD (gastroesophageal at's significant change MDS with an ARD (assessment 5/12 identified the resident terview of mental status) of we impairment), required persons for bed mobility, grand received hospice are plan dated 4/17/12 rescription that included the endmitted to the facility on antal Hospice services. Hospital stay the resident regalertness, level of mental status. The resident related thinking, inattention, ion and lethargy. The pat the resident was given a modate family members resident 24 hours a day and roice. It included that the one about Hospice care with delived his/her life and was ident's care plan failed to	F	279			

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F 279	Hospice agency.  On 4/23/12 at 2:55 p. resident lay in his/her closed and resting co displayed no signs of expression was peachis/her right side with reach.  On 4/23/12 at 4:00 p. resident lay on his/her remained with his/her signs of pain. Family bedside.  On 4/23/12 at 3:15 p. reported that a person in the resident's room a week as this was the family member Q and the Hospice services resident. Family men not think the facility step [the resident]'s pad as Family member Q repworking but when fammember Q stated the all their requests. Far overall staff was very  During an interview or care staff A reported hallways. Staff A was condition and reported care with his/her actives.	m. observation revealed the bed with his/her eyes mfortable. The resident pain. The resident's facial eful. The resident laid on his/her call light within  m. observation revealed the resident eyes closed and without remained at his/her  m. family member Q and R from the family remained 24 hours a day seven days e resident's wishes. Both R reported satisfaction of being provided to the ober Q reported he/she did the aff always checked his/her soften as they should. Sorted it depended who was only asked for staff, family facility staff was prompt on mily member R reported loving.	F	279			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 279	know.  On 4/24/12 at 4:05 p.1 asked how he/she known for the resident, he/sh brought the supplies to the resident's closet so closet and knew then.  Hospice staff S during 3:00 p.m. reported whoulding he/she check visited the resident. Hospice provided the facility who listed the resident's many provided. Hospice stangencies care plan in provided but he/she of the facility's care plan thospice provided the agency's care plan for reported the home he supplies, a nurse visit the home health aide. Staff S reported that a from Hospice come on needed. Staff S repoprovided turning and along with transferring reported transferring 2 weeks due to the reported that a from Hospice staff S also repoprovided turing and along with transferring 12 weeks due to the reported transferring 13 weeks due to the reported transferring 14 weeks due to the reported transferring 15 also reported transferring 16 along with transferring 17 along with transferring 18 along weeks due to the reported transferring 19 along with transferring 19 along weeks due to the reported transferring 19 along weeks along wee	m. direct care staff K when ew what Hospice supplied to the facility and put them in to he/she just checked the what Hospice supplied.  If an interview on 4/23/12 at the he/she entered the ed with the nurses then he/she reported that he/she ith a medication sheet that hedications Hospice aff S stated the Hospice cluded what Hospice id not know what was on thospice staff S reported facility with the Hospice of the resident. Staff S alth aide usually brought the ed two times a week and also visited 2 times a week. A social worker and chaplain nice a month and as reted the home health aid repositioning on her visit of the resident. Staff S and not happened in the last sident's declining condition. Experted that the home heed baths to the resident.	F	279			
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F 279	provided oral care. Sthealth aide also chan resident's bed on the resident.  On 4/24/12 at 4:00 p. he/she spoke to the February before and after visits medication was given aide provided care. Sonot know what hospic nurse always asked February and [hospice staff] what the hospice staff] what the hospice staff brought.  On 4/24/12 at 4:15 p. staff L revealed he/she plans only the main opertained to the resid Staff L stated he/she plan everything about only one person. When what services is personal care, or sup L reported it was communicated betwee staff but confirmed the comprehensive care.	nail care and with every visit raff S reported the home ged the linens on the days he/she bathed the  m. nursing staff D reported dospice nurse and aide so He/She reported that pain a before the home health taff D reported he/she did be supplied but the Hospice him/her if the resident if we [facility staff] told them he resident needed and the it in for the resident.  m. interview with nursing he only included on the care or current issues that ent's immediate needs. In did not have time to care the resident as he/she was en asked how staff would huch as additional baths, plies Hospice provided, staff from knowledge and was en the Hospice and facility at was not included in the plan.  m. 4/24/12 at 5:15 p.m. reported he/she would ordination of care with	F	279			
		no policy for care planning are of Hospice services.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	care plan to include the resident who received outside agency.  Review of resident orders dated 4/1/12 rediagnoses: multiple semuscle weakness, other insomnia, depressive pain, and hyperlipider. Review of the resident MDS (minimum data the resident with a BII Mental Status) score required extensive as mobility, transfers and of 2 people for dressicalso identified the resident on and off toilet and sexperienced impairmed extremities and used. The MDS identified the pain and received RC and passive 5 days in at least 15 minutes a Review of the annual identified the resident and received ROM act the last 7 calendar data day.	evelop a comprehensive ne coordination of care for a d Hospice services from an #18's signed physician evealed the following sclerosis, constipation, her behavioral problems, disorder, spasm of muscle, mia.  It's most recent quarterly set) dated 2/29/12 identified MS (Brief Interview of of 15/15 (cognitively intact), esist of one person for bed d required extensive assisting and toilet use. The MDS ident as not steady and only numan assistance with o standing position, moving surface-to-surface transfers, een on both sides of lower a wheelchair for mobility. The resident experienced no DM (range of motion) active in the last 7 calendar days for day.  MDS dated 12/7/11 with a BIMS score of 15/15, ctive and passive 5 days in anys for at least 15 minutes a	F	279			
	The cognition CAA (C	are area assessment) dated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	IG	<del></del>	05/0	2/2012
	OVIDER OR SUPPLIER COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	cognitive loss, was verified and experienced depit the resident experience assessment of pain of 12/7/11.  The psychosocial well identified the resident of the time, preoccuping preferred to be outsid breaks in the dining result of the time, preoccuping preferred to be outsid breaks in the dining result of the time, preoccuping preferred to be outsid breaks in the dining result of the time, preoccuping preferred to be outsid breaks in the dining result of the time, preoccuping preferred to be outsid breaks in the dining result of the time, and the dining result of 12/8/11 revealed the daily behavioral symptomic experienced physical multiple sclerosis, and the care plan with a rincluded the following assist of 1 with dressi assist with lower body only. Do a pain assess PRN (as needed), use complaints of BLE (bin muscle spasms or craassist and refuses us therapy) evaluations or restorative program a to participate in his/he [He/she] is refusing hithis time." The care prindividualized restorative program and the prefusion of the care prindividualized restorative program and the prefusion of the care prindividualized restorative program and the care prindividualized restorative pri	resident experienced no erbally hostile towards staff, ression. The CAA identified ced no pain with the last ompleted by staff on  I being CAA dated 12/8/11 preferred to be alone most ided with loss of past lifestyle; e smoking or take coffee from.  I daily living) CAA dated resident displayed almost otoms, was on celexa and ins for depression), limitations related to displayed was wheelchair bound.  The view date of 2/29/12 printerventions: "limited ing upper body, extensive ty, feeds self with set up help is sment every 3 months and the gentle massage for lateral lower extremity) amps, transfers with 1-2 ing a gait belt. PT (physical every 3 month and PRN for and encourage the resident er restorative program. is/her restorative program at olan lacked a specific	F	279			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630	B. WIN	G		05/0	2/2012
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	dated April 2012 reve A/PROM (active and and strength exercise and LE (lower extrem (repetitions) with 5 se (week). The restorati received these service week and 5 days one the Restorative Flows revealed the resident to illness during that 3 On 4/23/12 at 2:40 p. resident sat in his/her front porch smoking a feet rested on the whore resident used his/her He/she moved his/her couple of times, then wheelchair. The residhis/her hands and repfoot pedals.  On 4/24/12 at 10:00 at the resident participate exercising his/her uppose ach working ankles, and feet joints participated for about resident said "we are	t's Restorative Flowsheets aled the resident received passive range of motion) s to UE (upper extremities) ities) 10-15 reps cond hold, 3-7 days/wk ve aides signed the resident es 4 days each week for two week in April. Review of theets for the last 3 months only refused one week due 3 month period.  m. observation revealed the wheelchair outside on the a cigarette. The resident's eelchair's foot pedals. The arms without any problems. In wheelchair forward a locked the wheels of the dent moved his/her legs with desitioned his/her feet on the second in group exercise, were extremities.  12 at 1:15 p.m. revealed vided PROM to the mities. He/She performed the resident's knees, legs, s. The resident willingly 20 minutes. Then the done."	F	279			

Facility ID: N039001S

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE  2 N 5TH AVE  NTHONY, KS 67003		
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F 279	extremities because his arms. The resider staff came to his/her in p.m. He reported the the limited resources therapy.  On 4/23/12 at 3:40 p. confirmed the resider and he/she worked wa week. Staff U reporefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused for about a was ill, but was now prefused the resident participated living when he/she was the resident's lower eaffected by his/her disextremities.  On 4/24/12 at 3:50 p. the resident participated he/s resident refused at tirn not feeling well, but to resident still participated buring an interview of administrative nursing an interview of administrative nursing the prefused the prefused at tirn of feeling well, but to resident still participated administrative nursing an interview of administrative nursing the prefused at the prefused at tirn of feeling well, but to resident still participated at tirn of feeling well, but to resident still participated at tirn of feeling well, but to resident still participated at tirn of feeling well, but to resident still participated at tirn of feeling well participated at tirn of fe	rative program. He targeted his/her lower ne/she had no problems with at reported the restorative room every day around 1:30 facility did a good job with they had when it came to m. direct care staff U at had a restorative program ith the resident daily 5 times red the resident had eek or so because he/she participating in the program.  m. direct care staff A required assistance of 2 is and 1 assist with dressing Staff A reported the in his/her activities of daily as able. Staff A reported that extremities were more sease than his/her upper m. nursing staff D confirmed the din a restorative program. The was aware that the mes because of being sick or o staff D's knowledge the ted on a regular basis.  n. 4/24/12 at 4:20 p.m. g staff L reported he/she did	F	279			
	residents' care plans.	nce restorative programs on Staff L reported he/she programs on the care plans if					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SUI COMPLET	
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F 279 F 329 SS=E	On 4/24/12 at 5:05 p. administrative staff M the care plans to incluprograms.  The facility failed to dicare plan to include the restorative program.  483.25(I) DRUG REGUNNECESSARY DRUMNECESSARY DRU	e plan was to go home.  m. during an interview, revealed he/she expected ade residents' restorative  evelop a comprehensive ne resident's individualized  BIMEN IS FREE FROM UGS  regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate	F 2			
	adverse consequence should be reduced or combinations of the reduced or combinations of the reduced on a comprehence of the resident, the facility may be a comprehence of the resident, the facility may be a comprehence of the resident, the facility may be a comprehence of the resident, the facility may be a comprehence of the reduced	easons above.  ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER	NTER	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
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F 329	by: The facility census to residents sampled. Or reviewed for unnecess observation, interview facility failed to ensur medication regimens unnecessary drugs by medications with Black significant adverse ef administering PRN (a effectiveness, and the behaviors to ensure the medications.(#2,#6, 3#37)  Findings included:  Review of resident sheet dated 4-3-2012 diagnoses: unspecified hypertension, encept syndrome, hypothyro anemia, peptic ulcer, nausea / vomiting, ob personality, depression hemorrhoids, fracture	is not met as evidenced  otaled 35 residents with 17 of those, 10 residents were sary medications. Based on and record review, the e 9 of 10 sampled residents' remained free from the failure to monitor for sk Box Warnings (BBW), a fect, failure to follow up after so needed) medications for efailure to monitor the need for psychotropic the need for psycho	1	329	DEFICIENCY)		
	(minimum data set) w reference date of 8-2- (brief interview for me	nt's most recent annual MDS with an ARD (assessment 4-2011 revealed a BIMS ental status) score of 15/15, we MDS revealed the resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION  3	(X3) DATE SUF COMPLET	
		17E630	B. WIN	IG		05/0	2/2012
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	behavioral symptoms behaviors such as hiresistive to care). It all received antipsychotic antidepressant medical Review of the most of ARD of 2-9-2012 revents and antidepressant medical Review of the psychological and antidepressant medical Review of the psychological and antidepressant medical Review of the psychological Review of the psychological Articles and ativan (antianxiet the resident used the diagnoses of obsessing depressive disorder and ativan (antianxiet the resident used the diagnoses of obsessing depressive disorder and disturbance. It included to observe for side effective doses a problem for risk of a problem for	rnergy with no other mood or - (physical, verbal, or other titing, scratching self, so revealed the resident c, antianxiety and ations.  urrent quarterly MDS with an ealed the resident with a gnitively intact without signs thavioral symptoms. It also antipsychotic, antianxiety redications.  tropic medication use CAA aled the resident received ), zoloft (antidepressant) y medication). It revealed medications to manage we compulsive personality, and dementia with behavioral ed the staff should continue fects of medication, monthly c visits to ensure the LED	F	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE INTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	also failed to identify a BBW for the following the "BlackBoxRx.com increased risk of deat monitoring for clinical unusual changes in b identify Tylenol and L failure, and not to exc doses that exceed 40 compazine regarding.  Review of the resident 2-15-2012 through 4-1 nursing staff document nurses notes dated 3-1 resident picked at his nurse it did not itch, and The nurses notes date resident's skin red in picked at his/her hand.  Observation on 4-23-1 the resident wore a grarm, a type of protect sore by his/her thumb.  Observation on 4-23-1 the resident did not have resident did not have resident as care plan open sores on his/her redness and a small as one.  During an interview of	and Luvox. The care plan and direct staff to monitor for medications as identified in "web site: Abilify related to h, Zoloft regarding the worsening, suicidality, or ehavior. It also failed to ortab regarding acute liver eed acetaminophen at 00 milligrams per day, and risk of death.  It's nurses notes dated 25-2012 revealed the nted behaviors 2 times. The 24-2012 revealed the nted behaviors 2 times. The 24-2012 revealed the solor where the resident d.  2012 at 1:32 p.m. revealed eri-sleeve on his/her right ive covering, with an open of the color where the resident diverselve on his/her arm that presented with amount of blood on each are 4-24-2012 at 1:46 p.m. orted staff monitored all of ors. He/she reported	F	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER	NTER	·	2	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE INTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	also reported the resitimes. Direct care statinformed the nurse of experienced.  During an interview of direct care staff B reported to document behavior responsible to document the nurse of any behavior experienced and the discussed nurse D reported the nurse was to were any changes in reported there was not documentation for the behaviors. Licensed reput the behaviors in the pass on to the next standed.  During an interview of Consultant E confirment the fact monitoring regarding and confirmed the fact monitor the Black Bothe residents care plated the facility received a from consultant H buth had been done regardafter that.  During an interview of consultant H buth had been done regardafter that.	dent was resistant to care at ff C reported he/she any behaviors the resident for 4-24-2012 at 1:59 p.m. orted medication aides did fors that the nurses were ent. He/she would inform aviors the resident for the physician if there for the resident for the resident for the resident for the resident for the physician if there for the resident for the resident for the physician if	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G		05/0:	2/2012
	OVIDER OR SUPPLIER	ENTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	took that needed to be 2012. Consultant H sure where the facility monitoring and did nobe included in the play reported that he/she care plans with montare reported that for the looked at the nurses behaviors.  The facility failed to emedication regimen and unnecessary medication regimen for unnecessary medications for behaviors and the effect medications, BBW.  Review of resider physician order sheed diagnoses: hyperlipic essential hypertension flutter, esophageal edisorders, insomnia, myocardial infarct with 12-8-2011.  Review of the admissisted with an ARD of score of 10, moderate revealed the resident behavior problems.	the BBW medication they be monitored in January of reported that he/she was not by needed to document the ot realize the BBW needed to an of care. Consultant H did not normally review the hly reviews. He/She behavior monitoring he/she notes for documentation of the sensure the resident's remained free of tions by the failure to monitor fectiveness of the twors. The facility also failed	F	329			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	identify Remeron, Zol as medications with be need for special monisevere adverse effect.  According to BlackBoo Zoloft have a BBW reappropriately and obseversening, suicidality behavior. Tylenol (accregarding acute liver the 4000 milligrams per diacetaminophen-contains.)  Review of the medical (MAR) revealed the real the resident received 2 tablets for general contains.	an dated 3-20-2012 failed to oft and tylenol extra strength lack box warnings and the toring due to possible is.  xRX.com, Remeron and garding monitoring served closely for clinical, or unusual changes in setaminophen) has a BBW failure and not to exceed any including sining products.  tion administration record esident received ambien on a and 1-4-2012 for any follow up regarding	F	3329	DEFICIENCY)		
	follow up for effective Observation on 4-24- resident walked indep wheeled walker. Obseresident walked down the resident had to pic he/she steered it into	12 at 7:48 a.m. revealed the pendently using a front ervation revealed the the hall a couple of times ck up the walker because the wall.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION  3	(X3) DATE SUF COMPLET	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE M2 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	licensed nurse D reports psychiatrist that came and the nurse was to were any changes in reported there was not documentation for the behaviors. Licensed reput the behaviors in the pass on to the next staneeded.  During an interview of Consultant E confirmed monitoring regarding and confirmed the fact monitor the Black Boothe residents care plathe facility received a from consultant H but had been done regard after that.  During an interview of consultant H reported list of residents and the took that needed to be 2012. Consultant H resure where the facility monitoring and did not be included in the pla reported that he/she care plans with month reported that for the best of the stanes.	ent behaviors.  1. 4-24-2012 at 3:36 p.m.  1. orted the resident had a 1. monthly to see the resident 1. call the physician if there 1. behaviors. He/she also 1. specific routine 1. monitoring of the 1. are 24 hour report book to 1. are 26-2012 at 10:19 a.m. 1. are the lack of any behavior 1. are warning medications 1. are	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		DNSTRUCTION	(X3) DATE SU COMPLET	
		17E630	B. WIN	G		05/0	)2/2012
	COVIDER OR SUPPLIER	ENTER		212 N 5	ADDRESS, CITY, STATE, ZIP CODE STH AVE ONY, KS 67003		212012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	administrative nurse expectation was for simedications that had hour and document the effectiveness of their order sheet dated 4-diagnoses: demential anal fistula, renal fail hypertension, calculuthoric kidney disease region, cardiac dysthanemia, depressive of date of 3-16-2010.  Review of the most redata set) with an ARI date) of 2-15-2012 reinterview for mental scognitive impairment behaviors, and psychtrigger for further involved.	on 4-30-2012 at 3:00 p.m.  M reported his/her staff to follow up on probeen administered within an he findings as to the medications.  The staff to follow up on probeen administered within an he findings as to the medications.  The staff to follow up on probeen administered within an he findings as to the medications.  The staff to follow up on probeen administered within an he findings as to the medications of the staff to diverse of the viors and the failure to diverse effects of medications  The staff to follow up on probeen administered with behavioral disturbance, sure, hepatitis-C, diabetes, as of kidney, atherosclerosis, see,, spinal stenosis of lumbar ythmia, thrombocytopenia, disorder with a current admit of (assessment reference evealed a BIMS (brief status score) of 9, moderate and the staff to follow up on the staff to follow	F	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  B	(X3) DATE SUF COMPLETI	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	evidence of identifying as having a BBW and According to BlackBo BBW not to discontinu BBW that it can lead to diuresis, resulting in flu and Lotrab is a combinacetaminophen which regarding acute liver to grams in 24 hours.  Observation on 4-24-resident sat in recline call light within reach.  Observation on 4-26-sat in recliner working the pulleys for upper of the pul	e times a day for pain  an dated 2-21-2012 lacked g atenolol, lasix or the lortab the need for monitoring.  xRx.com Atenolol has a ue abruptly; Lasix has a o profound uid and electrolyte depletion nation medication with has a black box warning failure and not to exceed 4  12 at 9:55 am revealed the r chair reading newspaper,  2012 at 9:46 a.m. resident with restorative aide using extremity strengthening.  11 4-24-2012 at 3:36 p.m. 12 at 4-24-2012 at 3:36 p.m. 13 at emonthly to see the resident call the physician if there behaviors.  13 4-26-2012 at 10:19 a.m. 14 at 4-26-2012 at 10:19 a.m. 15 at the facility did not identify at Box warning medications ansultant E reported the of BBW medications from I not know what had been	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G_		05/02	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	consultant H reported list of residents and the took that need to be reconsultant H resure where they need monitoring and did not be included in the preported that he/she care plan with monthle reported that he/she developing a system med's.  The facility failed to emedication regimen reunnecessary medicate for severe adverse effective resident # 22.  - Review of residents orders dated 4/4/12 rediagnoses: presentle behavioral disturbance acetabulum, closed freclavicle, cardiac pacedementia with psychological pacedementia with psychological pacedementia with a BIMS status) score of 0 (see experienced inattentic hallucinations and decidentified the resident	n 4-26-2012 at 5:10 p.m.  he/she gave the facility and the BBW medication they monitored in January of eported that he/she was not led to document the cot realize the BBW needed plan of care. Consultant H did not normally review the y reviews. Consultant H did not assist the facility in for the monitoring of BBW emained free of ions by the failure to monitor fects of medications for the facility in dementia, dementia with es, closed fracture of acture	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER:  A. BUILD			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	person with eating.  Review of the admiss identified the resident (severe cognition defi and disorganized thin delusions. The MDS required extensive as mobility, transfer, wal toilet use, and dressir for personal hygiene.  Review of the cognitive assessment) dated 12 resident with anxiety/disturbances, poor nupounds. The CAA alsexperienced a short a forgetfulness and discresident lived in the pland delusions.  The care plan dated for common ADR (ad Seroquel which includa akasthesis, neuroleptic cardiac arrhythmia, helethargy, but failed to warning (serious or lifeffects) of elderly pating psychosis treated with antipyretics are at incite need to monitor elections.	essing toilet use and the MDS revealed the Illimited assistance of one ion MDS dated 12/21/11 with a BIMS score of 2 cit), experienced inattention king, hallucinations and also identified the resident sist of 2 persons for bed king in room and corridor, and almited assist of one experienced mild pain.  We CAA (care area 2/21/11 further assessed the agitation and behavioral attrition low weight of 115 co identified the resident attention span, confusion, orientation. It identified the asst through hallucinations  12/27/11 included monitoring verse drug reactions) of ded: anticholinergic effects, ic malignant syndrome, eart failure, falls and include the black box fe-threatening adverse side ents with dementia-related in a typical or conventional reased risk for death and	F	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		17E630	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	ENTER	<b>,</b>	21	EET ADDRESS, CITY, STATE, ZIP CODE  2 N 5TH AVE  NTHONY, KS 67003	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	common adverse drumedication used to trincluded observe and somnolence, dizzy, his seizures, malignant is nausea and vomiting diarrhea. The care publicated box warning for suicidal thinking or children in the care publicated thinking or children in the plant of residents who residents who residents who residents who residents who reconsultant H informed monitoring of the BBN Consultant H included electrolytes. The fact monitoring for suicidation the resident's plant on the resident's plant on the plant of care.  On 4/24/12 at 4:15 pustaff L confirmed he/st the plant of care.  On 4/24/12 at 5:10 pustaff M reported he/st were to be care plant consultant H told the they had to documen notes.  On 4/26/12 at 3:00 pustacility was working of the plant of care.	6/12 for staff to monitor for g reactions for zoloft (a eat depression) which I report insomnia, eadache, tremors, fatigue, syndrome like reaction, anorexia, constipation or olan failed to include the clinical worsening of nanges in behavior.  acy Report dated 1/25/12 of provided the facility with a received medications with a ning) and what the staff garding each drug listed. If the facility of the need for the facility failed to include the facility and electrolytes and care.  In administrative nursing the was unaware that BBW's	F	329			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	H revealed he/she had need to monitor for blad providing the facility witheir medications that 2012. Consultant H runaware that the blad be included in the plad he/she was to do with reported he/she did not his/her monthly review he/she had not done at Consultant H reported facility in developing a regarding black box with the facility provided runonitoring of black box with the facility failed to haplace for BBWs for the monitor for potential sthreatening side effect this resident.  Review of resident at Corder Sheet (POS) at the resident with the fidepressive disorder, of depressive affective of with delusional or deposteoporosis, and psy Review of the annual with an Assessment F	m. interview with consultant d notified the facility of the ack box warnings by with a list of residents and had a BBW in January eported he/she was ak box warnings needed to an of care or what else at the BBWs. Consultant Hot review care plans during ws. He/She confirmed anything further with BBWs. It he/she did not assist the any system or policies varnings.  In policy regarding the box warnings.  In a policy regarding the box warnings.	F	329			
	10-20-11 identified the	e resident with a BIMS					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	21	EET ADDRESS, CITY, STATE, ZIP CODE  2 N 5TH AVE  NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	He/she experienced of unclear or illogical flow switching from subject did not have mood properties. Review of the resident care Assessment Are revealed he/she had behaviors.  Review of the resident use CAA dated 10-10 doing well with reduct had no signs or sympt from the remeron, efform the resident's care plandly and the resident to discover possible to hallucinations or deluted to discover possible to hallucinations or deluted assessment for physical directed staff to monital negative behaviors and Review of the resident dated 1-25-12 identification (BBW) for aripirrazole venlafaxine regarding thinking and death but lacked BBW for these Review of the psychia dated 3-23-12 revealed behaviors. The recompositions in the recomposition of the psychia dated 3-23-12 revealed behaviors. The recompositions is subjected to the psychia dated 3-23-12 revealed behaviors. The recompositions is subjected to the psychia dated 3-23-12 revealed behaviors. The recompositions is subjected to the psychia dated 3-23-12 revealed behaviors. The recompositions is subjected to the psychia dated 3-23-12 revealed behaviors. The recompositions is subjected to the psychia dated 3-23-12 revealed behaviors.	e cognitive impairment. disorganized or incoherent, w of ideas, or unpredictable et to subject. The resident oblems or behaviors.  At's cognitive loss/dementia ea (CAA's) dated 10-10-11 eno negative moods or  At's psychotropic medication e-11 revealed he/she was etion of the abilify dose and etoms of adverse reactions exor, and abilify.  It an dated 10-20-11, updated directed staff to report sions to the nurse, attempt enderlying cause of sions, and provide an eal complaints. It also eor for an increase in end anxiety.  At's pharmacy consult notes ed Black Box Warning e, mirtazapine, and en increased risk for suicidal et the resident's plan of care e medications.  Atric consultation record ed no new concerns or d indicated resident #7 ession, senile dementia with	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G_		05/0:	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	Continued From page		F	329			
	as goal directed, thou	lamboyant, thought process					
	administered as need	d (MAR) revealed lortab led for pain 13 times during mes from 4-2-12 through d to document the					
	resident #7 at the sink	12 at 10:13 am revealed k brushing his/her teeth. The her self in the room without					
	Observation on 4-26- resident participated i	12 at 9:35 am revealed the in the "get fit activity".					
		g staff L confirmed the acked interventions for					
	An interview on 4-26- Consultant E confirme lacked monitoring for	ed resident's plan of care					
	An interview on 4-30- administrative nursing expectation of staff wa administered as need hour of providing and effectiveness of the m	g staff M reported the as to follow up on led medications within an to document the					
	An interview on 4-30-	12 at 4:00 PM with licensed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	IG_		05/02	2/2012
	OVIDER OR SUPPLIER COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page nursing staff T revealed document the effective indicated he/she was but did not have time.  The facility did not proadministration of as no box warnings.  Review of the facilities Medications policy dated direction the effectiveness of attraction the effectiveness of attraction the effectiveness of a monitor the effect	ed he/she often did not eness of the lortab. Staff T aware it needed to be done ovide a policy for eeded medications or black as Administering Pain ted 2/01/2005 revealed the for the documentation on a needed pain medications. Idequately assess and lack box warnings for effects.  #33's signed Physicians's d 4-1-12 revealed the wing diagnoses: etes mellitus, and depressive		329	DEFICIENCY)		
	00-15, experienced at status changes and re. The assessment also the assist of one pers living and was not ste position changes.  Review of the resident the resident had expert at 8:10 am and 1-14-7	t's Fall Risk CAA revealed rienced falls dated 1-6-12					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S COMPL	
		17E630	B. WIN	G	_   05	5/02/2012
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE 212 N 5TH AVE ANTHONY, KS 67003	•	, v = , = ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 329	The CAA indicated the personal alarm and rewith ambulation and the resident monthly and perform a fall assembly months or as needed.  Review of the resident revealed the resident Paxil for depression at The CAA indicated the delirium but the psychot assessed to be the Review of resident #3-16-2012 revealed he with falls, poor balance pressure with position for falls. The care planeded one personal personal hygiene, to discontinue paxil at for anxiety and restle instructed staff to moside effects including orthostatic hypotensic vision, and rash.  Review of care planes and restle instructed staff to moside effects including orthostatic hypotensic vision, and rash.  Review of care planes and restle instructed staff to initiate luvox as side effects including dizziness, seizures, resyndrome, rash, swe	taining standing positions. The resident needed a pad or required one person assist walker. Staff were to provide two way blood pressures resessment every three  This Psychotropic Risk CAA received Remeron and and appetitive stimulant. The resident did experienced motropic medications were realikely cause.  The standard deep resident did experienced motropic medications were realikely cause.  The standard deep resident did experienced problems received the resident did experienced did experienced did experienced problems received the resident did experienced did experience	F	329		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  A. BUILDING (X3) DATE SURVEY COMPLETED					
		17E630	B. WIN	G		05/02	2/2012
	ROVIDER OR SUPPLIER	ENTER	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	care plan lacked black thinking.  Review of the resider staff failed to include warnings for metform and tylenol not to excomposition for hepatotox.  Review of the resider through 4-26-12 reversed through 4-26-12 reversed through 4-26-12 reversed through 4-26-12 resident sleeping quitous consideration on 4-23-resident sat in the windown the hall.  Observation on 4-26-resident up in recline "help, help, help" and attempted to calm the providing 1 on 1, and the wheelchair.  Interview on 4-23-12 4:18 pm revealed her nurse, director of nurwhen seeking informates in the resident.  Interview on 4-26-12 staff L at 2:50 pm registers.	the box warning for suicidal  and monitor black box sin related to lactose acidosis seed 4 grams daily and scicity  and the suicidal seed 4 1-12 aled he/she received Xanax seed to document the sk of the MAR 10 times.	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G	<del>-</del>	05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	at 3:00 PM confirmed lacked monitoring for During a telephone in administrative nursing reported the expectation as needed medical administration and do the medications.  The facility failed to a monitor the effective medications and faile warnings for possible  Review of resident orders dated 4/10/12 diagnoses: acute ons failure congestive heas arcoidosis/fibrosis, hallergies, broncho spanypothyroidism, considisease, hemorrhoids  The review of the sign (minimum data set) wareference date) of 4/1 interview for mental sintact). The medication revealed a use of antimedications.  The psychotropic drug assessment) dated 4/1 took Lorazepam and chronic years of Lorazeration as medication of the sign (minimum data set) was reference date of antimedications.	with licensed Consultant E the resident's care plan black box warnings.  terview on 4-30-12 with g staff M at 3:00 PM ion of staff was to follow up tions within one hour of cument the effectiveness of  dequately assess and ess of as needed d to monitor for black box serious side effects.  # 6's signed physician revealed the following et of chronic respiratory art failure, stage 4 ypertension, depression, asms, insomnia, tipation, esophageal reflux inficant change MDS ith an ARD (assessment 9/12 revealed a BIMS (brief tatus) of 14 (cognitively	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		212	ET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 329	Review of the care placommon side effects and APAP (Acetamina interventions for monispecific or severe side warning) medications identify common and Lasix. According to Eclexa has BBW regasuicdality or unusual Acetaminophen, reganot to exceed a maxim (milligrams) in 24 hou diuresis with water an Review of the medical responses for the PR needed) medications following dates of the Mylanta on 1/24/12, 3 Ambien on 4/10/12  Ducolax on 2/13, 2/26	an dated 2/6/12 included for Celexa (antidepressant) ophen) but lacked toring and reporting of e effects of BBW (black box and the transport of the effects of BBW (black box and the transport of the effects for BlackBoxRx.com" website earding for clinical worsening changes in behavior, reding acute liver failure and mum dose of 4000 mg ars, Lasix lead to profound and electrolyte depletion.  Ition administration sheets ity did not follow up for N of the given PRN (as administered on the following medications:  16/10, 3/11, 3/12, 3/26/12		329	DEFICIENCY)		
	On 4/24/12 at 10:00 a the resident smiled ar U. The resident did no talking.	a.m. observation revealed and talked softly to direct staff of avoid eye contact when o.m. observation revealed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	:NTER		212	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	assisted the resident  During an interview of Consultant E confirm and monitor for BBW residents' plan of care the facility received a from the pharmacist of know what happened on 4/26/12 at 11:05 a reported that he/she physician to get the pand changed around that staff was to chare their effectiveness or On 4/26/12 at 5:10 p. consultant H revealed a list of resident # 6's Celexa and Lasix dat that he/she was not a documented. Consultant he/she was not a documented. Consultant not realize the BBW of care plan. Consultant not normally review the reviews and did not a developing a system medications.  During an interview we 4/30/12 at 3:00 p.m. I expectation was for se (as needed) medications.	t staff member V, who in the dining room.  In 4/26/12 at 10:19 a.m., ed the facility did not identify medications on the e. Consultant E confirmed list of BBW medications on 1/25/2012 but did not I to them after that.  Is a.m., licensed nursing staff T had worked with the pain medications reduced to work better. Staff T stated the PRN's (as needed) and I the PRN sheet.  In a.m., an interview with the provided the facility Black Box Warnings for ed 1/25/12. He/she reported sure where that needed to be that H reported the/she did needed to be included in the the care plan with monthly essist the facility in for the monitoring of BBW  In the Administrative staff M on the/she reported that the the that the document the hour and document the	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG_		05/0	2/2012
	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page The facility failed to p monitoring of the BBV medications.  The facility failed to e medication regime ref medications by failure effectiveness of the P the need for the medi monitor the severe ac medications with BWV identification of any ac physician could deter medication outweigh  - The Review of resic orders dated 3/4/12 re diagnoses: chronic of disease, restless leg s disease, diabetes me gastro-esophageal re and osteopenia.  Review of the significat data set) with an ARD date) of 4/18/12 reveal experienced mood pre-	rovide a policy on the V's and the PRN  Insure the resident's mained free of unnecessary to monitor the RN medication to ensure cation. The facility failed to diverse reactions of the W, to ensure the diverse side effects so the mine if the benefits of the the side effects.  Ident # 16's signed physician evealed the following ostructive pulmonary syndrome, coronary artery esyndrome, coronary artery esyndrome, flux disease, fibromyalgia, ant change MDS (minimum of (assessment reference)		329	DEFICIENCY)		
	feeling down for 2-6 d staying asleep or slee during the 14 day lool reported being tired w poor appetite/overeat day look back period. concentrating and fee 2-6 days of the look b The psychosocial wel	lays, trouble falling asleep or eping to much 7-11 days to back period. The resident with little energy 2-6 days; ing 12-14 days during the 14 He/she also had trouble sling bad about his/herself ack period of 14 days. I- being CAA (care area 19/12 identified the resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUII	A. BUILDING				
		17E630	B. WIN	G	<del></del>	05/0	2/2012
	ROVIDER OR SUPPLIER  OF COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ON SHOULD BE COMP IE APPROPRIATE	
F 329	Effexor and Lasix was side effects; but failed to monitor for BBW for Effexor, Metoprolol, a "BlackBoxRx.com" for discontinue abruptly of Lasix, may lead to propose and electrolyte deplet amounts. Effexor not medication abruptly the over a 2 week period. Review of the medicated April 2012 indictup of the given PRN of done for the following medications:  Oxycodone on 2/5, 2/3/1, 3/2, 3/5, 3/8/3/10, 3/31, 3/2, 3/5, 3/8/3/10, 3/30, 3/31, 4/1 times 4/12, 4/14/12.  Maalox on 3/6/12.  Tylenol on 2/12 times 2/27, 2/28, 3/4, 3/4, 3/4, 3/4, 3/4, 3/4, 3/4, 3/4	an dated 4/25/12 revealed so care planned for common do to identify and direct staff or the following medications and Lasix. According to reflect to cardiac risk, and produced divided to divided to divided to divided to discontinue the me dose should be tapered of time.  Attion administration sheets cated the staff failed to follow (as needed) medications and dates and the following  All 22 times 2, 2/25, 2/28, 2/29, 2, 3/11, 3/13, 3/14, 3/24, 2, 4/3, 4/6, 4/7, 4/8, 4/10,	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		2	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE INTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From page	e 42	F	329			
	Miralax on 2/1, 2/2, 2/3/18, 4/12, 4/13, 4/15	/5, 2/7, 2/9, 2/26, 3/3, 3/15, , 4/17/12.					
		a.m. observation revealed the care plan meeting and ying.					
		a.m.,observation revealed eely with his/her roommate s noted.					
	Consultant E confirme and monitor for BBW residents' plan of care the facility received a	e. Consultant E confirmed list of BBW medications on 1/25/2012 but did not					
	reported that he/she he physician to get the period and changed around	ain medications reduced to. Staff T stated that staff 's (as needed) and their					
	a list of resident #16's Effexor, Metoprolol ar He/she reported that it needed to be docun Consultant H reported	I he/she provided the facility B Black Box Warnings for and Lasix dated 1/25/12. The/she was not sure where mented in the record. I he/she did not realize the cluded in the care plan. I that he/she did not are plan with monthly					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	medications.  During an interview w 4/30/12 at 3:00 p.m. rexpectation was for si (as needed) medicatic administered within 1 effectiveness of the m.  The facility failed to propose medications.  The facility failed to emedication regime remedications by failure effectiveness of the Patheneed for the medications with BW identification of any aphysician could determedication outweight.  The Review of residences dated 3/20/12 diagnoses; diabetes remplications type 2 diabetic renal complications constipation, neurological diabetes, morbid obest	ith Administrative staff M on te/she reported that the taff to follow up on the PRN ons that had been hour and document the tedication.  Tovide a policy on the V's and the PRN  Insure the resident's mained free of unnecessary to monitor the RN medication to ensure cation. The facility failed to liverse reactions of the V, to ensure the diverse side effects so the mine if the benefits of the the side effects.  Item #13's signed physician revealed the following mellitus with out of chronic obstructive asthma, ations, depressive disorder, eathy lesion in the kidney, e, exocytosis of nasal personal history of urinary e, congestive heart failure,	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G	<del> </del>	05/02	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	hyperlipidemia esoph Review of the annual with an ARD (assessi 12/15/11 and a BIMS status) score of 15 ind cognitively intact. Ove symptoms indicate the following verbal and be directed toward others Review of the cognatiansessment) dated 3/ residents cognitive statesident had negative Review of the care pla planned the more corbut failed to identify the box warning) for Cele "BlackBoxRx.com" ware garding for clinical variables in be the monitoring of the sand BUN.  Review of the medical indicate that no follow following dated of the Mylanta on 1/15, 1/18 on the PRN sheet  Tusselon Perles on 4/16 the PRN sheet	with stent, angioplasty nageal reflux disease.  MDS (minimum data set) ment reference date) of (brief interview of mental dicating the resident is erall presents of behavioral eresident has had the behavioral symptoms is eveloss CAA (care area 22/12 revealed the latus was intact though the behaviors  and dated 1/17/12 care mon side effects of Celexa he more serious BBW (black xa and Bumex. According to ebsite Celexa has BBW	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 45	F	329			
		3/25, 3/26, 3/27, 3/28 x's 2 3/31 x's 3 on the PRN					
	Milk of Magnesia on 3	3/10, 3/15/12					
	Ducolax Suppository	on 2/1, 2/11, 3/10, 3/16/12					
	Tylenol on 3/10/12						
	2/22 x's 2, 2/24, 2/26 3/8, 3/9, 3/10 x's 2, 3/ 3/16, 3/18, 3/20, 3/21	15, 2/5, 2/12 x's 2 2/13, 2/17, , 2/29, 3/1, 3/2, 3/4, 3/5, 3/7, /11, 3/12, 3/13, 3/14, 3/15, , 3/23, 3/24 x's 2, 3/25 x's 4, , 4/21, 4/22 x's 2, 4/24/12					
	resident sitting in the recliner watching tele	m. observation made of the living room in a large vision. Resident interacted and the staff, resident					
	accused staff of wron the staff for not leaving	m. observation of the frowning and yelling, and g doings. Resident blamed ag his/her with the call light ere still in the room with					
	Consultant E confirmand monitor for BBW residents' care plan. (facility received a list	Consultant E confirmed the of BBW medications from 25/2012 but did not know					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER	•	212	T ADDRESS, CITY, STATE, ZIP CODE N 5TH AVE FHONY, KS 67003		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		LD BE	(X5) COMPLETION DATE
F 329	On 4/26/12 at 11:05 a had reported that he/physician to get the pand changed around to chart the PRN's (at and then chart the effimedication.  On 4/26/12 at 5:10 p. consultant H revealed a list of resident #13's Celexa and Bumex dereported that he/she needed documenting he/she did not realized included in the care pathat he/she did not nowith monthly reviews in developing a systemedications.  The facility failed to pathat he/she did not now ith monthly reviews in developing a systemedications.  During an interview was 4/30/12 at 3:00 p.m. It expectation was for sexpectation was for sexpectation regime remedications by failure effectiveness of the Ferthe need for the medication in the medication regime remedications by failure effectiveness of the Ferthe need for the medication in the medication regime remedications by failure effectiveness of the Ferthe need for the medication.	a.m., licensed nursing staff T she had worked with the ain medications reduced Staff T stated that staff was a needed) on the PRN sheet ectiveness of the  m., an interview with the he/she provided the facility and sheet extensions and sheet extensions are where that the sheet example of the BBW needed to be alan. Consultant H reported the BBW needed to be alan. Consultant H reported examply review the care plan and did not assist the facility of the monitoring of BBW rovide a policy on the Ws and the PRN with Administrative staff M on the sheet example of the PRN ons that had been hour and document the needication.	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDI			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	NTER	•	21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329 F 425 SS=E	physician could deter medication outweigh	W, to ensure the dverse side effects so the mine if the benefits of the the side effects.  IACEUTICAL SVC -		329 425			
33-E	The facility must providrugs and biologicals them under an agree §483.75(h) of this par unlicensed personnel law permits, but only supervision of a license A facility must provide (including procedures acquiring, receiving, cadministering of all driven needs of each results.	ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse.  e pharmaceutical services that assure the accurate dispensing, and ugs and biologicals) to meet sident.  loy or obtain the services of t who provides consultation provision of pharmacy					
	by: The facility census to facility reported all 35 medications. Based review the pharmacis implement an on goin monitor for black box	is not met as evidenced staled 35 residents. The residents received on interview and record t failed to develop and g system to identify and warnings (serious and/or ffects of medications with a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  A. BUILDING (X3) DATE SURVEY COMPLETED					
		17E630	B. WIN	G	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425	BBW (black box warn had the potential to at received medications  Findings included:  - Review of the Pharmatevealed consultant Hist of residents who medded to monitor regressive of the Pharmathrough March 2012 Lidentification or follow BBWs.  On 4/24/12 at 4:15 p. staff L confirmed he/st the plan of care.  On 4/24/12 at 5:10 p. staff M reported he/st needed to be included He/She stated consult 2 months ago they had the nurses' notes.  On 4/26/12 at 3:00 p. facility was working on the plan of this on the plan of the	ing). This deficient practice fect all 35 residents who macy Report dated 1/25/12 I provided the facility with a eceived medications with a ing) and what the staff garding each drug listed. Acy Reports from February acked any further up with monitoring of m. administrative nursing he did not include BBWs on m. administrative nursing he was unaware that BBW's doin the plan of care. I tant H told the facility about do document BBWs on m. consultant E reported the na BBW system but it was so time.  In interview with consultant donotified the facility of the ack box warnings by with a list of residents and had a BBW in January	F	425			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET	
		17E630	B. WING	G	05/0	2/2012
	OVIDER OR SUPPLIER COMMUNITY CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CO 212 N 5TH AVE ANTHONY, KS 67003	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 425	he/she was to do with reported he/she did no his/her monthly review he/she had not done. Consultant H reported facility in developing a regarding black box with the facility provided regarding the monitor. The facility pharmacist implement a system to deficient practice had residents who receives 483.60(c) DRUG REGULAR, ACT Outline to the drug regimen of the drug regimen of the reviewed at least once pharmacist.	n of care or what else the BBWs. Consultant H ot review care plans during ws. Consultant H confirmed anything further with BBWs. It he/she did not assist the any system or policy's varnings. In policy or procedure ing of black box warnings. It failed to develop and o monitor for BBW. This the potential to affect all 35 and medications. GIMEN REVIEW, REPORT N each resident must be the a month by a licensed		428		
	by: The facility census to residents sampled. Or reviewed for unneces	is not met as evidenced staled 35 residents with 17 of those, 10 residents were sary medications. Based on or, and record review the the pharmacist				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	NTER	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 428	recommendations regmedications with a BI 9 or 10 residents. Th irregularities regardin needed) medications failed to identify irregumonitoring of behavior (#2,# 6, #7, #10, #13, Findings included:  - Review of resident sheet dated 4-3-2012 diagnoses: unspecified hypertension, enceph syndrome, hypothyrotanemia, peptic ulcer, nausea / vomiting, ob personality, depressivhemorrhoids, fracture behavioral disturbance face sheet revealed at 12-6-2000.  Review of the resider (minimum data set) we reference date of 8-24 (brief interview for me cognitively intact. The felt tired or had little ebehavioral symptoms behaviors such as hir resistive to care). It all received antipsychoticantidepressant medical review of the most of the most of the system of the system of the most of the system	garding the need to monitor ack Box Warning (BBW) for e pharmacist failed to report g the follow up of PRN (as for 6 of 10 residents and ularities regarding the rs for 1 or 10 residents.  # 16, #22, #33, #37)  # 2's signed physician order concluded the following and neurotic disorder, alopathy, syphilitic brain dism, hyperlipidemia, bulimia, constipation, sessive compulsive re disorder, internal of ankle, and dementia with e. Review of the admission in admission date of admission date of the resident revealed a BIMS and status) score of 15/15, and the resident regy with no other mood or (physical, verbal, or other titing, scratching self, so revealed the resident contact and the resident	F	428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	behavioral symptoms antianxiety and antide Review of the psycho dated 8-24-2011 reve abillify (antipsychotic and ativan (antianxiet the resident used the diagnoses of obsesside depressive disorder a disturbance. It includ to observe for side effective Review of the care plate a problem for risk of cofficient of daily living and resinterventions to remingeri-sleeves and therewhile awake to prevendirected staff to remotime and change daily the monitoring of the included common side medications but did nomonitoring and report associated with the abilify, zoloft and Luvito identify and direct severe potentially life effect) for the following in the "BlackBoxRx.coto increased risk of demonitoring for clinical unusual changes in both sidentifications."	gnitively intact with no received antipsychotic, epressant medications.  tropic medication use CAA aled the resident received ), zoloft (antidepressant) y medication). It revealed medications to manage we compulsive personality, and dementia with behavioral ed the staff should continue fects of medication, and consultant visits to ensure the dose).  an dated 2-14-2012 included decline in strength, Activities dent choices. It included d and encourage the use of aband gloves to both arms ant obsessive picking. It we the geri-sleeves at bed of behaviors. The care plan e effects of different	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	doses that exceed 40 compazine regarding  Review of the resident 2-15-2012 through 4-1 nursing staff document nurses notes dated 3-1 resident picked at his nurse it did not itch, and The nurses notes date resident's skin was represident had picked at note and the resident wore and gram, a type of protect sore by his/her thumbout the resident did not have redident as care pland open sores on his/her redness and a small at one.  During an interview of direct care staff C represident's behaviors of picking as smearing of bowel mealso reported the resident did not nearly some aring of bowel mealso reported the resident's behaviors of picking as smearing of bowel mealso reported the resident did not nearly some aring of bowel mealso reported the resident did not nearly some aring of bowel mealso reported the resident did not nearly some aring of bowel mealso reported the resident did not nearly some aring of bowel mealso reported the nurse of experienced.	eed acetaminophen at 00 milligrams per day, and risk of death.  It's nurses notes dated 25-2012 revealed the need behaviors 2 times. The 124-2012 revealed the need the forearm, and told the need 3-26-2012 revealed the need 3-26-2012 revealed the need in color where the need this/her hand.  It is nurses notes dated 25-2012 revealed the need 3-26-2012 revealed the need 3-26-2012 revealed the need in color where the need this/her hand.  It is nurses notes dated 25-2012 revealed the need 3-26-2012 revealed the need 3-26-2012 revealed this/her right inverse covering, with an open need 3-2012 at 1:32 p.m. revealed are geri-sleeve on his/her inverse need and revealed multiple in arm that presented with amount of blood on each are needed to staff monitored all of ors. He/she reported it his/her arm and the overment on things. He/she dent was resistant to care at	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  7 COMMUNITY CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP C 212 N 5TH AVE ANTHONY, KS 67003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	responsible to docum the nurse of any beha experienced and the nurse D reports of the paychiatrist that came and the nurse was to were any changes in reported there was not documentation for the behaviors. Licensed reput the behaviors in the pass on to the next shapeded.  During an interview of Consultant E confirmed the facility received a from consultant H but had been done regard after that.  During an interview of consultant H reported list of residents and the took that needed to be 2012. Consultant H r sure where the facility monitoring and did not be included in the pla	ors that the nurses were ent. He/she would inform aviors the resident nurses followed up on it.  In 4-24-2012 at 3:36 p.m. orted the resident had a monthly to see the resident call the physician if there behaviors. He/she also a specific routine monitoring of the nurse D reported he/she just ne 24 hour report book to nift or called the physician if  In 4-26-2012 at 10:19 a.m. and the lack of any behavior psychotropic medications illity did not identify or a warning medications on an Consultant E reported list of BBW medications he/she did not know what ding the recommendations  In 4-26-2012 at 5:10 p.m. he/she gave the facility and the BBW medication they be monitored in January of the eported that he/she was not a needed to document the at realize the BBW needed to not care. Consultant He did not normally review the	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		17E630	B. WIN	IG_		05/0	2/2012
	OVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	reported that for the blooked at the nurses in behaviors.  The Pharmacist failed regarding the monitor management and the associated with psych facility also failed to a recommendation regarmedications with Black #2.  Review of resident physician order sheet diagnoses: hyperlipid essential hypertension flutter, esophageal eff disorders, insomnia, of myocardial infarct with 12-8-2011.  Review of the admissisted with an ARD of score of 10, moderate revealed the resident behavior problems.  Review of the CAA'S mood and behavior diassessment.  Review of the care plaidentify Remeron, Zolidentify	lehavior monitoring he/she notes for documentation of a to identify irregularities ing of behavior effectiveness of medication notropic medications. The ct upon the pharmacist arding the need to monitor ek Box Warnings for resident at # 10 undated signed included the following lemia, depressive disorder, not an admission date of a cognitive impairment. It did not have any mood or dated 12-20-2011 revealed and not trigger for further an dated 3-20-2012 failed to oft and Tylenol extra ns with black box warnings stall monitoring due to	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	According to BlackBo Zoloft have a BBW re appropriately and obsworsening, suicidality behavior. Tylenol (acregarding acute liver 4000 milligrams per dacetaminophen-contal Review of the medical (MAR) revealed the real-2-2012 for insomnia restlessness without a effectiveness of the market Review of the MAR for the resident received 2 tablets for general on follow up for effect 2-15-2012 received by follow up for effectiveness of the market walked independent walked independent walked down the resident walked down the resident had to pick he/she steered it into During an interview and direct care staff C reproducemented the resident had to pick he/she steered it into During an interview of licensed nurse D reproposed in the nurse was to	xRX.com, Remeron and garding monitoring erved closely for clinical or unusual changes in etaminophen) has a BBW failure and not to exceed ay including ining products.  Ition administration record esident received ambien on and 1-4-2012 for any follow up regarding redication.  In February 2012 revealed tylenol 325 mg (milligrams) liscomfort on 2-9-2012 with riveness, and again on elenol for back pain with noness.  In a 7:48 a.m. revealed the rendently using a front ervation revealed the the hall a couple of times ock up the walker because the wall.	F	428			

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		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	·	21:	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	put the behaviors in the pass on to the next sheeded.  During an interview of Consultant E confirmed monitoring regarding and confirmed the factorial factorial for the Black Boothe residents care plated the facility received a from consultant H but had been done regard after that.  During an interview of consultant H reported list of residents and the took that needed to be 2012. Consultant H resure where the facility monitoring and did not be included in the pla reported that he/sheed care plans with monther reported that for the belooked at the nurses of behaviors.  During an interview of administrative nurse of expectation was for set the set of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the belooked at the nurses of the plant for the plant for the belooked at the nurses of the plant for	e specific routine e monitoring of the hurse D reported he/she just he 24 hour report book to hift or called the physician if  1 4-26-2012 at 10:19 a.m. hed the lack of any behavior psychotropic medications hillity did not identify or high warning medications on high Consultant E reported hist of BBW medications he/she did not know what he/she gave the facility a he BBW medication they he monitored in January of he eported that he/she was not he realize the BBW needed to high reviews. He/She hehavior monitoring he/she hotes for documentation of  1 4-30-2012 at 3:00 p.m. he reported his/her high reviews at 3:00 p.m. he reported his/her high reviews at 3:00 p.m. he reported his/her high reported h	F	428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  7 COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	regarding the follow used medications and their facility failed to act up recommendation regarded medications with Black #10.  Review of resident order sheet dated 4-diagnoses: dementia anal fistula, renal failthypertension, calculus chronic kidney diseass region, cardiac dysrhyanemia, depressive date of 3-16-2010.  Review of the most redata set) with an ARE date) of 2-15-2012 reinterview for mental secognitive impairment. behaviors, and psych trigger for further investigated at enolol 25 medicated at the month of April received at enolol 25 medicated at the month of April received at enolol 25 medicated at the month of April received at enolol 25 medicated at the month of April received at enolol 25 medicated at the month of April received at enolol 25 medicated at the month of April received at the care place with the care place wi	to identify irregularities p of PRN (as needed) effectiveness and the on the pharmacist arding the need to monitor ek Box Warnings for resident  # 22's signed physician 4-12 included the following with behavioral disturbance, are, hepatitis-C, diabetes, s of kidney, atherosclerosis, e., spinal stenosis of lumbar ythmia, thrombocytopenia, isorder with a current admit  ecent annual MDS (minimum o (assessment reference evealed a BIMS (brief tatus score) of 9, moderate It also revealed mood, otropic medications did not estigation.  tion administration record	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	According to BlackBo BBW not to discontinu BBW that it can lead to diuresis, resulting in flu and Lotrab is a combina cetaminophen which regarding acute liver to grams in 24 hours.  Observation on 4-24-resident sat in recline call light within reach.  Observation on 4-26-sat in recliner working the pulleys for upper of	arx.com Atenolol has a be abruptly; Lasix has a co profound aid and electrolyte depletion nation medication with a has a black box warning failure and not to exceed 4 and 12 at 9:55 am revealed the rechair reading newspaper, and 12 at 9:46 a.m. resident a with restorative aide using extremity strengthening.  In 4-24-2012 at 3:36 p.m. and the resident had a semonthly to see the resident call the physician if there behaviors.  In 4-26-2012 at 10:19 a.m. and the facility did not identify a Box warning medications insultant E reported the portal form and the semonth of BBW medications from a line that the semonth of t	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E630	B. WIN	G		05/0	2/2012
	COVIDER OR SUPPLIER	ENTER	•	212	T ADDRESS, CITY, STATE, ZIP CODE N 5TH AVE I'HONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	reported that he/she care plan with mont reported that he/she developing a system med's.  The facility failed to recommendation remedications with Bla #22.  - Review of resident orders dated 4/4/12 diagnoses: present behavioral disturbar acetabulum, closed clavicle, cardiac pacedementia with psychological depression, pain an Review of the most (minimum data set) resident with a BIMS status) score of 0 (sexperienced inattentiallucinations and didentified the reside 2 persons with bed room and corridor, opersonal hygiene.	e plan of care. Consultant H e did not normally review the hly reviews. Consultant H e did not assist the facility in n for the monitoring of BBW  act upon the pharmacist garding the need to monitor ack Box Warnings for resident  t #37's signed physician's revealed the following le dementia, dementia with nces, closed fracture of fracture of acromial end of cemaker, low body weight, nosis and behaviors,	F	428			
	identified the reside	esion MDS dated 12/21/11 nt with a BIMS score of 2 eficit), experienced inattention					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER:  A. BUI			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG_		05/0	2/2012
	ROVIDER OR SUPPLIER  OF COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE	(X5) COMPLETION DATE
F 428	delusions. The MDS required extensive as mobility, transfer, wal toilet use, and dressir for personal hygiene.  Review of the cognitive assessment) dated 12 resident with anxiety/disturbances, poor nupounds. The CAA alsexperienced a short as forgetfulness and discresident lived in the pand delusions.  The care plan dated for common ADR (ad Seroquel which includakasthesis, neurolepticardiac arrhythmia, helethargy, but failed to warning (serious or lifeffects) of elderly pating psychosis treated with antipyretics are at incitation the need to monitor experienced to monitor experienced and the need to monitor experienced to monitor experienced and the need to monitor experienced and the need to monitor experienced and somnolence, dizzy, he seizures, malignant is nausea and vomiting,	king, hallucinations and also identified the resident sist of 2 persons for bed king in room and corridor, and and experienced mild pain.  We CAA (care area 2/21/11 further assessed the agitation and behavioral strition low weight of 115 so identified the resident attention span, confusion, orientation. It identified the asst through hallucinations  12/27/11 included monitoring effects, ic malignant syndrome, eart failure, falls and include the black box include the black box included the black box included the black box included in a typical or conventional reased risk for death and lectrolytes.  and dated 12/27/11 included 6/12 for staff to monitor for greactions for zoloft (a eat depression) which	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER:  A. E			PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	revealed consultant Hist of residents who medded to monitor reg Consultant H informer monitoring of the BBV #37 which Consultant thinking and electrolytic include the monitoring electrolytes on the residence of the plan of care.  On 4/24/12 at 4:15 pustaff L confirmed he/st the plan of care.  On 4/24/12 at 5:10 pustaff M reported he/st were to be care plantic consultant H told the strength had to document notes.  On 4/26/12 at 3:00 pustacility was working of and BBW systems but this time.  On 4/26/12 at 5:10 pustacility was working of and BBW systems but this time.  On 4/26/12 at 5:10 pustacility was working of and BBW systems but this time.	clinical worsening of anges in behavior.  acy Report dated 1/25/12 I provided the facility with a eceived medications with a ing) and what the staff garding each drug listed. If the facility of the need for the facility of the need for the facility failed to go for suicidal thinking and sident's plan of care.  In administrative nursing the did not include BBWs on the nurses'  In administrative nursing the was unaware that BBW's ed. He/She stated facility about 2 months ago as BBWs on the nurses'  In consultant E reported the nabehavioral monitoring the was not in operation at the native with consultant donotified the facility of the ack box warnings by with a list of residents and had a BBW in January	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG	<del></del>	05/0	2/2012
	ROVIDER OR SUPPLIER  7 COMMUNITY CARE CE	NTER	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	be included in the pla he/she was to do with reported he/she did n his/her monthly review he/she had not done a Consultant H reported facility in developing a regarding black box w  The facility provided r monitoring of black box  The facility failed to a recommendation rega for BBWs for a reside medications with a bla  - Review of resident: Order Sheet (POS) at the resident with the f depressive disorder, of depressive affective of with delusional or deposteoporosis, and psy  Review of the annual with an Assessment F 10-20-11 identified th score of 12, moderate He/she experienced of unclear or illogical flow switching from subject did not have mood pro-	n of care or what else the BBWs. Consultant H ot review care plans during ws. Consultant H confirmed anything further with BBWs. d he/she did not assist the any system or policy's varnings.  no policy regarding the ox warnings.  ct upon the pharmacists' arding the need to monitor int who received ack box warning.  #7's signed Physician's and dated 4-1-2012 revealed ollowing medical diagnoses: osteoarthrosis, major lisorder, senile demential oressive features, vchosis.  Minimum Data Set (MDS) Reference Date (ARD) of the resident with a BIMS the cognitive impairment. disorganized or incoherent, w of ideas, or unpredictable t to subject. The resident oblems or behaviors.  It's cognitive loss/dementia are (CAA's) dated 10-10-11	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER:  A. BUIL			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	NTER	·	21:	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	use CAA dated 10-10 doing well with reduct had no signs or symp from the remeron, eff.  The resident's care pi 1-24-12 and 4-24-12, hallucinations or delu to discover possible un hallucinations or delu assessment for physi directed staff to monit negative behaviors at contained common si monitor but it failed to potential severe side regarding aripirrazole venlafaxine.  Review of the resider dated 1-25-12 identific (BBW) for aripiprazole venlafaxine regarding thinking and death.  Review of the resider Administration Record administered as need March 2012 and 10 ti 4-23-12 but staff faile effectiveness on the I Observation on 4-24-resident #7 at the sint signs and signs are signs and signs are signs and signs are signs and signs are sign	at's psychotropic medication 0-11 revealed he/she was tion of the abilify dose and of the abilify dose and of the abilify.  Ian dated 10-20-11, updated directed staff to report sions to the nurse, attempt underlying cause of sions, and provide an cal complaints. It also tor for an increase in and anxiety. The care plan de effects for staff to address the monitoring of effects (black box warning) and, mirtazapine, and of increased risk for suicidal of MAR) revealed lortab led for pain 13 times during mes from 4-2-12 through d to document the	F	428			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	NTER	<b>'</b>	21:	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	difficulty.  Observation on 4-26-resident participated in the An interview on 4-26-consultant E confirmed care lacked monitoring. An interview on 4-26-consultant E confirmed care lacked monitoring. An interview on 4-30-administrative nursing expectation of staff wadministered as need hour of providing and effectiveness of the manursing staff T reveal document the effective indicated he/she was but did not have time. The facility did not proadministration of as now warnings.  Review of the facilitie Medications policy day policy lacked direction the effectiveness of a The pharmacist failed.	12 at 9:35 am revealed the n the "get fit activity".  12 at 2:50 PM with g staff L confirmed the elacked interventions for warnings.  12 at 3:00 PM with led the resident's plan of g for BBW.  12 at 3:00 PM with g staff M reported the least of follow up on led medications within an to document the ledications.  12 at 4:00 PM with licensed led he/she often did not leness of the lortab. Staff T laware it needed to be done lovide a policy for leeded medications or black	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER  7 COMMUNITY CARE CE	NTER	·	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	medications and their facility failed to act up recommendation regamedications with black resident.  - Review of resident: Order Sheet and date resident with the follow hypothyroidism, diabed disorder.  The MDS dated 3-14-with a BIMS score 00 experienced an acute changes and received assessment also reveasses of one person fliving and was not steposition changes.  Review of the resident revealed the resident Paxil for depression at The CAA indicated the delirium but the psychnot assessed to be the Review of the care plastaff to discontinue paneeded for anxiety an instructed staff to morside effects including orthostatic hypotensic vision, and rash.  Review of the care plastaff to morside effects including orthostatic hypotensic vision, and rash.	reffectiveness and the on the pharmacist's arding the need to monitor is adding the need to monitor is box warnings for this.  #33's signed Physicians's add 4-1-12 revealed the wing diagnoses: etes mellitus, and depressive etes etes etes etes etes etes etes et	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		17E630	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	and report side effects drowsiness, dizziness malignant syndrome, vomiting, constipation hepatotoxicity. The coff the black box warn. The care plan also reinclude and monitor be metformin related to lenot to exceed 4 grams hepatotoxicity  Review of the resident through 4-26-12 reversed times but staff failer effectiveness on back. Observation on 4-23-resident sleeping quies. Observation on 4-24-resident sat in the whown the hall.  Observation on 4-26-resident up in recliner "help, help, help" and attempted to calm the providing 1 on 1, and the wheelchair.  Interview on 4-23-12 of 4:18 PM revealed he/nurse, director of nurse when seeking informates ident	s including headache, s, seizures, neurological rash, sweating, nausea or n, diarrhea, and are plan lacked monitoring ing for suicidal thinking. vealed the staff failed to lack box warnings for actose acidosis and tylenol is daily and monitor for  It's MAR dated 4 1-12 aled he/she received Xanax and to document the is of the MAR 10 times.  In at 1:21 PM revealed the elelchair and propelled self  In at 12:00 PM revealed the is the resident is yelling out	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E630	B. WING		05/	02/2012	
	COVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 212 N 5TH AVE ANTHONY, KS 67003	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Interview on 4-26-12 at 3:00 PM confirmed lacked monitoring for During a telephone in administrative nursin revealed the expecta on as needed medica administration and do the medications.  The pharmacist failed regarding the follow medications and their facility failed to act up recommendation regmedications with black resident.  The Review of resioneders dated 4/10/12 diagnoses: acute one failure congestive he sarcoidosis/fibrosis, lallergies, broncho sphypothyroidism, considisease, hemorrhoid:  The review of the sig (minimum data set) we reference date) of 4/1 interview for mental sintact). The medication	corted the resident's plan of any for black box warnings.  with licensed Consultant E at the resident's plan of care is black box warnings.  Interview on 4-30-12 with g staff M at 3:00 PM ation of staff was to follow up ations within one hour of coument the effectiveness of the did to identify irregularities ap of PRN (as needed) in effectiveness and the conthe pharmacist arding the need to monitorick box warnings for this dent # 6's signed physician revealed the following set of chronic respiratory art failure, stage 4 hypertension, depression, asms, insomnia, stipation, esophageal reflux	F 43	28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	The psychotropic drug assessment) dated 4/took Lorazepam and chronic years of Lorazunsuccessful attempts. Review of the care placommon side effects and APAP (Acetamininterventions for monispecific or severe side warning) medications identify common and Lasix. According to ECelexa has BBW regasuicdality or unusual Acetaminophen, reganot to exceed a maxim (milligrams) in 24 houdiuresis with water and Review of the medical responses for the PR needed) medications following dates of the Mylanta on 1/24/12, 3  Ambien on 4/10/12  Ducolax on 2/13, 2/26	g use CAA (care area 19/12 revealed the resident Celexa. The resident had zepam use with previous is to stop the medication.  an dated 2/6/12 included for Celexa (antidepressant) ophen) but lacked toring and reporting of effects of BBW (black box The care plan failed to severe side effects for BlackBoxRx.com" website arding for clinical worsening changes in behavior, rding acute liver failure and mum dose of 4000 mg rs, Lasix lead to profound and electrolyte depletion.  Ition administration sheets ity did not follow up for N of the given PRN (as administered on the following medications:  6/10, 3/11, 3/12, 3/26/12	F	428			
	1 y 10 11 01 11 11 20, 3/ 14	, O.Z.1, O.Z.71 12					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	17E630	B. WIN	G	<del> </del>	05/0	2/2012
NAME OF PROVIDER OR SUPPLIER  ANTHONY COMMUNITY CARE CEN	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE ANTHONY, KS 67003		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
the resident smiled an U. The resident did no talking.  On 4/26/12 at 12:10 p. the resident smiled at assisted the resident in During an interview on Consultant E confirme and monitor for BBW residents' plan of care the facility received a I from the pharmacist or know what happened to hanged around to that staff was to chart their effectiveness on their effectiveness on the Collect and Lasix date that he/she was not su documented. Consultant not realize the BBW not care plan. Consultant not normally review the reviews and did not as developing a system for medications.	.m. observation revealed d talked softly to direct staff of avoid eye contact when .m. observation revealed staff member V, who in the dining room.  1. 4/26/12 at 10:19 a.m., and the facility did not identify medications on the consultant E confirmed list of BBW medications in 1/25/2012 but did not to them after that.  1m., licensed nursing staff T and worked with the ain medications reduced to work better. Staff T stated the PRN's (as needed) and the PRN sheet.  1m., an interview with he/she provided the facility Black Box Warnings for and 1/25/12. He/she reported are where that needed to be ant H reported he/she did eeded to be included in the H reported that he/she did e care plan with monthly	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER  OF COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (CONTRACTION OF CORRECTION OF CORRECT OF CO	JLD BE	(X5) COMPLETION DATE
F 428	expectation was for s (as needed) medicative administered within 1 effectiveness of the management of the management of the medications.  The facility failed to purchase medications.  The pharmacist failed regarding the follow us their effectiveness and upon the pharmacist the need to monitor management of the medications.  The Review of resident of the medication of th	ne/she reported that the taff to follow up on the PRN ons that had been hour and document the nedication.  rovide a policy on the V's and the PRN  to identify irregularities p of PRN medications and d the facility failed to act recommendation regarding nedications with Black Box #6.  dent # 16's signed physician evealed the following ostructive pulmonary syndrome, coronary artery llitus, hypertension, flux disease, fibromyalgia,  ant change MDS (minimum of (assessment reference)	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X3) A. BUILDING			CONSTRUCTION	(X3) DATE SUF COMPLET	
	17E630	B. WIN	G		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER  ANTHONY COMMUNITY CARE C	ENTER	Ì	212	T ADDRESS, CITY, STATE, ZIP CODE N 5TH AVE IHONY, KS 67003		
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
The psychosocial we assessment) dated 4 experienced behavior admission to the facing Review of the care provided assessment of the care provided assistance of	back period of 14 days. fell- being CAA (care area l/19/12 identified the resident or problems prior to lity.  lan dated 4/25/12 revealed as care planned for common d to identify and direct staff or the following medications and Lasix. According to or Metoprolol not to due to cardiac risk, and rofound diuresis with water stion if given in excessive at to discontinue the the dose should be tapered d of time.  ation administration sheets cated the staff failed to follow (as needed) medications g dates and the following  2/22 times 2, 2/25, 2/28, 2/29, 0, 3/11, 3/13, 3/14, 3/24, 2, 4/3, 4/6, 4/7, 4/8, 4/10,	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WING	<b>3</b>		05/0	2/2012
	COVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	4/22, 4/23 times 2, 4/4/26/12  Miralax on 2/1, 2/2, 2, 3/18, 4/12, 4/13, 4/15  On 4/24/12 at 11:45 at the resident finished sat in his/her room cromator on 4/26/12 at 10:30 at the resident visited from the resident visited from the pharmacist of the facility received a from the pharmacist of know what happened on 4/26/12 at 11:05 are ported that he/she I physician to get the pand changed around was to chart the PRN effectiveness on the III on 4/26/12 at 5:10 p. consultant H revealed a list of resident # 6's Effexor, Metoprolol at He/she reported that it needed to be docur Consultant H reported	2/10, 4/20 times 2, 4/21, 24/ times 2, 4/25 times 2, 4/25 times 2, 4/25 times 2, 4/3, 3/15, 4/17/12.  a.m. observation revealed the care plan meeting and ying.  a.m., observation revealed eely with his/her roommate is noted.  a.m. 4/26/12 at 10:19 a.m., ed the facility did not identify medications on the e. Consultant E confirmed list of BBW medications on 1/25/2012 but did not to them after that.  a.m., licensed nursing staff T had worked with the ain medications reduced to. Staff T stated that staff is (as needed) and their PRN sheet.  a.m., an interview with it he/she provided the facility Black Box Warnings for and Lasix dated 1/25/12. he/she was not sure where	F	128			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	IG_		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Consultant H reported normally review the creviews and did not a developing a system medications.  During an interview w 4/30/12 at 3:00 p.m. hexpectation was for so (as needed) medicationational medications administered within 1 effectiveness of the monitoring of the BBV medications.  The facility failed to promonitoring of the BBV medications.  The pharmacist failed regarding the follow up their effectiveness and upon the pharmacist the need to monitor monitoring for resident.  The Review of residents orders dated 3/20/12 diagnoses; diabetes recomplications type 2 diabetic renal complications type	at that he/she did not are plan with monthly sists the facility in for the monitoring of BBW with Administrative staff M on ne/she reported that the taff to follow up on the PRN consthat had been hour and document the nedication.  Tovide a policy on the V's and the PRN  to identify irregularities p of PRN medications and d the facility failed to act recommendation regarding nedications with Black Box #16.  Sent #13's signed physician revealed the following nellitus with out of chronic obstructive asthma, rations, depressive disorder, eathy lesion in the kidney, e, exocytosis of nasal personal history of urinary e, congestive heart failure,	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		212	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	hyperlipidemia esoph Review of the annual with an ARD (assess 12/15/11 and a BIMS status) score of 15 inc cognitively intact. Ove symptoms indicate th following verbal and to directed toward other.  Review of the cognat assessment) dated 3, residents cognitive stresident had negative.  Review of the care pliplanned the more corbut failed to identify the box warning) for Cele "BlackBoxRx.com" we regarding for clinical vunusual changes in bithe monitoring of the and BUN.  Review of the medical indicate that no follow following dated of the Mylanta on 1/15, 1/18 on the PRN sheet.	MDS (minimum data set) ment reference date) of (brief interview of mental dicating the resident is erall presents of behavioral e resident has had the behavioral symptoms s  ive/loss CAA (care area /22/12 revealed the atus was intact though the behaviors  an dated 1/17/12 care mmon side effects of Celexa ne more serious BBW (black xa and Bumex. According to ebsite Celexa has BBW	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630	B. WING	3		05/0	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER		212	ET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE ITHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	3/29 x's 3, 3/30 x's 2, sheet.  Milk of Magnesia on 3  Ducolax Suppository  Tylenol on 3/10/12  Lortab on 1/2, 1/3, 1/2/22 x's 2, 2/24, 2/26, 3/8, 3/9, 3/10 x's 2, 3/3/16, 3/18, 3/20, 3/21 3/26, 3/28, 4/19 x's 2, On 4/23/12 at 2:00 p. resident sitting in the recliner watching tele with both the resident smiled.	3/25, 3/26, 3/27, 3/28 x's 2 3/31 x's 3 on the PRN 3/10, 3/15/12 on 2/1, 2/11, 3/10, 3/16/12 15, 2/5, 2/12 x's 2 2/13, 2/17, 2/29, 3/1, 3/2, 3/4, 3/5, 3/7, 11, 3/12, 3/13, 3/14, 3/15, 3/23, 3/24 x's 2, 3/25 x's 4, 4/21, 4/22 x's 2, 4/24/12 m. observation made of the living room in a large vision. Resident interacted is and the staff, resident	F	428	BEHOLIKOT)		
	accused staff of wron the staff for not leavin earlier but the staff we his/her at the time.  During an interview o Consultant E confirme and monitor for BBW care plan. Consultant received a list of BBW pharmacist on 1/25/2 happened to them aft	frowning and yelling, and g doings. Resident blamed g his/her with the call light ere still in the room with  n 4/26/12 at 10:19 a.m., ed the facility did not identify medications on the resident' E confirmed the facility I medications from the 012 but did not know what					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E630	B. WIN	IG_		05/0	2/2012	
	OVIDER OR SUPPLIER	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 428	physician to get the pand changed around. to chart the PRN's (as and then chart the eff medication.  On 4/26/12 at 5:10 p. consultant H revealed a list of resident # 6's Celexa and Bumex dareported that he/she in needed documenting he/she did not realize included in the care pathat he/she did not nowith monthly reviews in developing a system medications.  The facility failed to pathat he/she did not now with monthly reviews in developing a system medications.  The facility failed to pathat he/she did not now with monthly reviews in developing a system medications.  During an interview was did not now the facility failed to pathat he/she did not now the period of the medications.  The pharmacist failed regarding the follow up their effectiveness and upon the pharmacist the need to monitor medication.	she had worked with the ain medications reduced Staff T stated that staff was a needed) on the PRN sheet fectiveness of the  m., an interview with the he/she provided the facility Black Box Warnings for ated 1/25/12. He/she was not sure where that the consultant H reported the BBW needed to be alan. Consultant H reported formally review the care plan and did not assist the facility of the monitoring of BBW rovide a policy on the N's and the PRN  with Administrative staff M on the/she reported that the taff to follow up on the PRN ons that had been hour and document the nedication.  I to identify irregularities ap of PRN medications and did the facility failed to act recommendation regarding nedications with Black Box	F	428				
F 441	Warnings for resident 483.65 INFECTION C	CONTROL, PREVENT	F	441				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		17E630	B. WIN	IG	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER  Y COMMUNITY CARE CE	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441 SS=C	SPREAD, LINENS  The facility must esta Infection Control Progsafe, sanitary and conto help prevent the deformation of disease and infection (a) Infection Control Facility must esta Program under which (1) Investigates, control in the facility; (2) Decides what progshould be applied to a (3) Maintains a record actions related to infection determines that a respreyent the spread of isolate the resident. (2) The facility must program under will transport (3) The facility must program direct contact will transport (3) The facility must repand after each direct and washing is indicting professional practice.  (c) Linens Personnel must hand	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.  Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and dof incidents and corrective ctions.  If of Infection Control infections are individual resident; and individual resident; and individual resident; and incidents and corrective ctions.  If of Infection in Control Program ident needs isolation to infection, the facility must be or infected skin lesions the residents or their food, if is institute disease. In the disease is equire staff to wash their ct resident contact for which	F	441			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G		05/0:	2/2012
	OVIDER OR SUPPLIER	INTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE NTHONY, KS 67003	00/01	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE		
F 441	by: The facility reported Based on observation	is not met as evidenced a census of 35 residents. n, interview and record	F	441			
	cleaning of resident fl isolation rooms to pre diseases including C-	ed to develop policies for loors and surfaces in event the transmission of Diff (clostridium difficile). had the potential to affect all					
	HIV-1 (aids virus), HE C (Hepatitis- C), Stap Pseudomonas aerugi (vancomycin resistan MRSA (Methacillin Ro	2-92, PH7Q ultra will kill BV (hepatitis B virus), HEP-					
	guidelines on cleanin areas located at www the following recomm disinfectants are reco patient-care areas. We check product labels indications for use, at Ensure adequate clear environmental surface especially items likely feces and surfaces the Consider using an Er	hen choosing a disinfectant, for inactivation claims,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E630	B. WIN	G		05/02	2/2012
	ROVIDER OR SUPPLIER  COMMUNITY CARE CE	NTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 112 N 5TH AVE ANTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	label instructions; ger (e.g., household chlor appropriately diluted a EPA-registered hospi effective against Clos Hypochlorite-based d effective in preventing transmission in units of Clostridium difficile in:  Observation on 4/24/2 housekeeping staff J resident's room on the Cobservation on 4/26/12 a housekeeping staff P resident's room on the Interview on 4/26/12 a housekeeping staff P spectrum disinfectant surfaces (sinks, fixture)  On 4/26/12 at 5:00 p.consultant E he/she adisinfecting a room af confirmed the facility addressed C-Diff and resident's rooms after resident with C-Diff. Cofacility did not have at C-Diff.  The facility failed to define the control of the c	nvironmental surface ning in accordance with heric sources of hypochlorite rine bleach) also may be and used. (Note: Standard tal disinfectants are not tridium difficile spores.) isinfectants may be most g Clostridium difficile with high endemic rates of fection.  12 at 9:30 a.m. revealed mopped the floor in 1 e South hall.  12 at 10:15 a.m. revealed mopped the floor in another e North hall.  at 11:30 a.m. revealed used pH7Q ultra (a broad ) for all the floors and es, and toilets).  m. during an interview with httempted to find a policy on the isolation. Consultant E had no policy that for the disinfecting of the being occupied by a consultant E confirmed the hay residents currently with evelop policies for the coms and floors to prevent	F	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		05/02	2/2012	
NAME OF PROVIDER OR SUPPLIER  ANTHONY COMMUNITY CARE CENTER			•	21	EET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE NTHONY, KS 67003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		